

**QUARTERLY CONTRACT MONITORING REPORT (QCMR)  
CLIENT MOVEMENT REPORT  
PATH PROGRAM**

<b>USTF PROJECT CODE:</b>	<b>REPORTING QUARTER: (CHECK ONE):</b>		
<b>NAME OF AGENCY:</b>	<b>JULY 1 TO SEPTEMBER 30</b>	1	<input type="checkbox"/>
<b>NAME OF PROGRAM:</b>	<b>OCTOBER 1 TO DECEMBER 31</b>	2	<input type="checkbox"/>
<b>PERSON COMPLETING FORM/PHONE #:</b>	<b>JANUARY 1 TO MARCH 31</b>	3	<input type="checkbox"/>
<b>DATE SUBMITTED:</b>	<b>APRIL 1 TO JUNE 30</b>	4	<input type="checkbox"/>
<b>CHECK AGENCY REPORTING QUARTER:</b> ● →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	4 <input type="checkbox"/>		

1.	2.	3.	4.	5.	6.
Beginning Active Caseload (First Day of Qtr.)	New Enrollees to Program Element During Qtr.	Transfers to Program Element During Qtr	Transfers From Program Element During Qtr	Terminations From Program Element During Qtr.	Ending Active Caseload (Last Day of Qtr.)

TARGET GROUPS		7. Number of Target Group Members:	
		NEW ENROLLEES	TRANSFERS
7A.	Clients who were Discharged from State Hospitals and Enrolled in this Program Within 30 Days of Discharge.		
7B.	Clients who were Discharged from County Hospitals and Enrolled in this Program Within 30 Days of Discharge.		
7C.	Clients who were Discharged from a Short-Term Care Facility/Involuntary Psychiatric Unit and Enrolled in this Program within 30 Days of Discharge.		
7D.	Clients who were Discharged from another Hospital and Enrolled in this Program Within 30 Days of Discharge.		

## CLIENT MOVEMENT REPORT

**BEGINNING ACTIVE CASELOAD:** Consist of clients who have had at least one face-to-face contact with your agency in the last 90 days and were active on the last of the previous quarter. **The Beginning Caseload is equal to the Ending Caseload of the previous reporting quarter.**

**NEW ENROLLEES:** Clients who were newly enrolled in your agency during the reporting quarter and were enrolled in this program element prior to enrollment in any other program element within your agency.

**TRANSFERS TO:** Refers to clients who are already registered within your agency in another program element, and are being transferred to this program element service.

**TRANSFERS FROM:** Refers to clients who are registered within your agency in this program element, but for whom this program has ceased to provide services on an ongoing basis and for whom another program element of your agency is going to provide services on an ongoing basis.

**TERMINATIONS:** Clients who are no longer receiving services at your agency.

**ENDING ACTIVE CASELOAD:** Is the active caseload on the last day of the reporting quarter. It is calculated in the following manner: **Add #1** (Beginning Active Caseload) **+ #2** (New Enrollees) **+ #3** (Transfers To). **Subtract #4** (Transfers From) and **#5** (Terminations) = **Ending Caseload #6.**

**DUPLICATED COUNT OF TARGET GROUP MEMBERS AMONG “NEW ENROLLEES” AND “TRANSFERS TO”:** Refers to the count of clients who entered this program element within 30 days of their discharge from the hospital. The definitions of “New Enrollees” and “Transfers To” are the same as stated above. Therefore, the number of “New Enrollees” or Transfers To” indicated in categories 7A, 7B, 7C, and 7D, should be the same or less than the number indicated in items #2 and #3 of this form.

- 7A. STATE HOSPITAL:** Refers to the states six psychiatric hospitals located in New Jersey only: Greystone Park, Trenton, Ancora, Arthur Brisbane, Hagedorn, and Ann Klein.
- 7B. COUNTY HOSPITALS:** Refers to the six county hospitals located in New Jersey only: Essex, Burlington, Camden, Hudson, Bergen, and Union.
- 7C. SHORT-TERM CARE FACILITIES:** Refers to inpatient, community-base mental health treatment facilities that provide acute care and assessment services to the mentally ill. The Commissioner, Department of Human Services must designate the facility.
- 7D. OTHER HOSPITAL:** Refers to any psychiatric hospital or psychiatric unit within a hospital that is not a State, County or STCF Hospital in New Jersey; include as “Other” any Facility located outside of New Jersey.

**QUARTERLY CONTRACT MONITORING REPORT (QCMR)  
LEVEL OF SERVICE REPORT  
PATH PROGRAMS**

**USTF PROJECT CODE:**

**NAME OF AGENCY:**

**NAME OF PROGRAM:**

**PERSON COMPLETING FORM/PHONE #:**

**DATE SUBMITTED:**

**REPORTING QUARTER: (CHECK ONE)**

**JULY 1 TO SEPTEMBER 30** 1 ☐

**OCTOBER 1 TO DECEMBER 31** 2 ☐

**JANUARY 1 TO MARCH 31** 3 ☐

**APRIL 1 TO JUNE 30** 4 ☐

**CHECK AGENCY REPORTING QUARTER:**

1 ☐

2 ☐

3 ☐

4 ☐

1. Of the Ending Caseload how many individuals are:

A. Medicaid/Familycare Enrolled

B. Medicaid/Familycare Non-Enrolled

(1A. + 1B. must equal ending caseload)

2. Total Number of Unduplicated Homeless Individuals Outreached in this Quarter  
(Do not count those reported as outreached in previous QCMR's this contract year)

3. Total Number of Newly Enrolled Clients who are MICA

Individual Group

4. Number of Face-to-Face On-Site Contacts with enrolled Clients



5. Number of Face-to-Face Off-Site Contacts with enrolled Clients



6. Units of Service (Sum of 4 and 5)



7. Aggregate Number of Telephone Hours with or on behalf of enrolled Clients

8. Of the Total Number of **Individual** face to face contacts how many are provided to individuals who are:

A. Medicaid/Familycare Enrolled

B. Medicaid/Familycare Non-Enrolled

(8A. + 8B. must equal Total Number of Individual Contacts)

9. Of the Total Number of **Group** face to face contacts how many are provided to individuals who are:

A. Medicaid/Familycare Enrolled

B. Medicaid/Familycare Non-Enrolled

(9A. + 9B. must equal Total Number of Group Contacts)

10. Total Number of Enrolled Clients Linked to Program/Services in the following areas:

a. Financial

e. Medical/Dental

b. Long-Term Housing

f. Mental Health

c. Temporary Housing

g. Habilitation/Rehabilitation

d. Drug/Alcohol Program

h. Referred to Screening or for Psych. Eval.

11. Number of Enrolled Clients for Whom Funds were Expanded for Housing Services in this Qtr.

12. Number of Enrolled Clients Receiving Supportive/Supervisory Svs in a Res. Setting in this Qtr.

## PATH PROGRAM

**HOMELESS CLIENT:** Any individual who suffers from serious illness and who lacks a fixed, regular and adequate nighttime residence or an individual whose primary nighttime residence is a homeless shelter.

**HOMELESS MICA CLIENTS:** An individual who suffers from serious mental illness and who lacks a fixed, regular and adequate nighttime residence or an individual whose primary residence in a homeless shelter who is also a mentally ill chemical abuser.

**FACE-TO-FACE CONTACTS:** Refers to direct contact with or on behalf of the consumers for 15 continuous minutes. If a contact exceeds more than 15 continuous minutes, count as multiple contacts. If one staff member serves between two and six clients simultaneously, count as one group contact per client (group contacts of seven or more clients are not reportable). Travel time is to be excluded from overall contact time.

**TELEPHONE CONTACTS:** Aggregate phone time with or on behalf of the consumer.

**ON-SITE:** Means services provided at the agency offices.

**OFF-SITE:** Means services provided in any location other than the agency offices.

**UNITS OF SERVICE:** Sum of items 4 and 5.

**OUTREACH:** Means any staff contact with a homeless individual in order to introduce the program or staff, establish a relationship, assess the individual, or attempt to engage and enroll the individual in the PATH program.

**ENROLLED:** An individual is considered as enrolled when he/she has agreed to allow PATH to provide a service and an intervention is made on their behalf. (Enrollment is accomplished by opening a case record (completing a USTF).

**ALCOHOL AND DRUG TREATMENT SERVICES:** Services, including linkages to detox and rehab, providing referral for or specialized counseling, education and support to consumers with mental illness who also have addiction issues.

**HABILITATION AND REHABILITATION SERVICES:** Activities designed to restore or enable an individual to customary activity through education and therapy. Linkages to Partial Care, Work First, Supported Employment or other vocational services.

**FINANCIAL:** Food Stamps, General Assistance, SSI, SSD.

**TEMPORARY HOUSING:** Motel/Hotel Placement, Shelter, Transitional Housing, etc.

**LONG-TERM HOUSING:** Apartment, Rooming House, Boarding House, etc.

**MENTAL HEALTH SERVICES:** Linkage to psychiatrist, counseling services, outpatient services, intensive family support services, medication monitoring, Integrated Case Management, or other programs that assist individuals to stabilize symptoms through pharmacological intervention, counseling, ongoing advocacy, support and monitoring.

**SCREENING OR PSYCH EVAL:** Different from above in that it is a one time event for assessment purposes.